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Snell: Ramifications of DRGs on Health Care Delivery in New Jersey

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RAMIFICATIONS OF DRGS ON HEALTH CARE DELIVERY IN NEW JERSEY

Margaret **Snell**¹

Abstract: Diagnosis Related Groups, a prospective payment plan, were pilot tested in New Jersey starting in 1980. Within three years, they became the cost containment mechanism governing the state's hospital patient care. Many changes resulted from the impact of this financial mechanism; hospitals, doctors, health care providers and patients were all affected as well as Visiting Nurse Associations and Health Maintenance Organizations. Because Diagnosis Related Groups have been utilized longer in New Jersey than in any other state, ramifications and emerging trends can be identified. These changes may be of interest to health occupations teachers to help them acclimate their programs to the Diagnosis Related Groups phenomenon and to prepare for future changes.

Change has become a way of life. Change is experienced so frequently and

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in so many ways that at times it is treated quite casually. In health care this casualness often is extended to sophisticated advances that are occurring with almost predictable frequency in medical technology and in biochemistry.

Not too many years ago we were even moderately unimpressed about the introduction of the cost control mechanism called Diagnosis Related Groups (DRGs). New Jersey was the first state to utilize this new cost control mechanism. At the time of its introduction few health care practitioners knew what the letters DRG represented. Now it is difficult to find anyone associated with health care delivery who is not aware of DRGs.

DRGs were introduced in New Jersey on a pilot basis in 1980 with one third of the hospitals participating the first year, one third the next, and all hospitals by the third year. Indeed, almost before the health care community had learned what the initials stood for, this system that has, or is, revolutionizing health care delivery was in place and people were expected to use it. DRGs represented a definite challenge to hospitals to operate within the rates established by the DRG system. New Jersey hospitals without exception have had to undergo major adjustments and adaptations and, as a result, some are on the brink of bankruptcy.

Some of the changes that have occurred in health care in New Jersey as a result of DRGs are presented in this article. While cost containment mechanisms are found nationally, seemingly some of the changes in New Jersey have not occurred elsewhere. Because New Jersey implemented DRGs a few years earlier than other states, the changes occurring in New Jersey may forecast developments in other states. Certainly the opportunity to compare may be worthwhile.

The information reported in this paper reflects interviews with

administrators of 4 health care agencies. **Frurther** information from the interviews may be obtained on request from the author. Specific statements are not credited to any particular individual.

Impact on Hospitals

Very often when DRGs are discussed the question, "How have hospitals fared under the cost control mechanism?" is asked as though there were a simple answer. No general statement reflects an accurate assessment of the impact of DRGs on hospitals (medical centers). Each facility should be considered separately in the context of the following two questions: (a) How financially sound was the hospital when DRGs came into being? and (b) How effective is the hospital's marketing procedures? Answers to these questions seem to be closely guarded secrets.

These questions also represent a starting point in considering whether hospitals are surviving or thriving under the DRG system. Of vital importance, for example, are classification of patients served by the institution, type of medical problems they have, and length of convalescent periods before they can be returned to their homes or placed in extended care facilities. Although the DRG formula contains a variable providing a higher payment level to hospitals with a complex case load, some hospitals engage in selective admissions practices. The DRG fixed base payment, whether or not it means to do so, provides an incentive for hospitals to specialize in the most profitable types of health care. There is also a financial incentive to select less severely **ill** patients within a DRG group and **to** choose patients with social and economic characteristics requiring relatively short hospital stays. Thus, medicare patients with complex problems provide decreased financial rewards to hospitals. Some hospitals are reluctant to treat very

ill patients.

In addition, hospitals need a sophisticated system to insure accuracy of primary and secondary diagnoses because the payment system is generated from the diagnosis. Using the system accurately, therefore, influences rate of occupancy, length of stay, and insurance payments received. Inappropriate DRG coding can result in decreased reimbursement for a hospital. Teaching doctors how to use the system initially was by trial and error. Doctors' orientation to DRGs varied from one institution to another, so hospitals initially varied widely in their ability to use DRGs with any degree of efficiency. Some doctors, particularly the older, established ones, resented the system. It took them time to comply with the requirements. It also made them accountable. Hospitals had to spend considerable effort to encourage some physicians to use DRGs accurately.

Teaching and Non-teaching Hospitals

In New Jersey, major teaching hospitals, teaching hospitals, and non-teaching hospitals receive different reimbursement for the same illness. Major teaching hospitals get the highest reimbursement rate because they have higher costs associated with their major teaching functions than teaching hospitals. Additionally, even in the major teaching category there is reported to be a sight difference in the DRG reimbursement. Non-teaching hospitals may get the smallest payments. Many hospital administrators may feel major teaching **hospitals** have an unfair advantage.

Endowments/Business Ventures

Also, endowments considerably influence how well a hospital is faring under **DRGs**. In some instances, hospitals, particularly those with little or no endowments, are trying to survive by entering into business ventures not

typically utilized in the past. Some form corporations with other businesses or incorporate. Others utilize 'unbundling,' another survival technique, in which two hospitals jointly purchase a piece of equipment they both need or offer a service to their patients at a third site separate from the two hospitals. Thus, the hospitals save the total expense of purchasing and maintaining expensive equipment or providing a particular service for their patients. DRGs offer no reimbursement for capital equipment, maintenance, and updating equipment. It is expected that unbundling will be utilized in the future by an increasing number of hospitals.

Health Maintenance Organizations

In addition to these survival techniques, some hospitals are adapting to changing trends in health care delivery by making contractual agreements with Health Maintenance Organizations (**HMOs**). An HMO will send all its subscribers to a particular hospital which offers an agreed upon lower rate than other hospitals in the area. Naturally, **hospitals** offering the best financial arrangements are selected resulting in an assured supply of patients, even though their hospital stays may be shorter than patients with other types of insurance. **Thus**, some hospitals are forced to cut back on services in order to offer those reduced rates. An element of competition is being introduced where previously **little** existed.

Professional Review Boards

Professional Review Organizations (PROS) also influence hospitals in their practice of conducting almost daily reviews of some patients. For those reasons and others, hospitals are becoming more cost effective than ever before.

Another cause for concern is non-payment of bills. If a particular

hospitalization or other aspect of care is not covered by health insurance and a patient is unable to pay the **bill**, hospitals must absorb the cost. When a patient is ready to go home and the family does **not** want the person at home, hospitals must continue care until other arrangements can be made. Some hospitals have even had patients abandoned in their care by families who give fictitious information or move out of the area. These occasions are rare, but only a few instances can seriously deplete resources.

In the past, hospitals were able to recoup some of these deficits and others associated with DRGs by setting fixed costs for "**outlyings**" relatively high. This was possible because for a time outlying did not fall within the DRG system. **Outlyings** are those incidents of care that do not require overnight hospitalization. Typical examples are a D & C (dilation and curettage) and removal of a cyst from the breast. Recent evolutions of New Jersey guidelines control what can be charged for **outlyings**. As a result hospital administrators will be faced with a dilemma of how to pay for expenses not paid under the **DRG** system. This is a problem hospitals are not discussing with any amount of publicity, but it is of concern to almost all of them.

Utilization of Personnel

Hospitals must find ways to cut expenses and one way is efficient utilization of personnel. To increase cost cutting, unnecessary or non-vital functions have been discontinued in many hospitals. Unfortunately many of these cost reduction practices are related to maintaining or improving the quality of care patients receive. Essentials must be provided. Many little "extras" are stopped. Nursing care may be reduced to a dollar value orientation with the quality of care getting little consideration. When a

hospital is having financial difficulties, personnel is one area that administrators examine. Often it seems an easy way to cut costs. For example, members **of** the staff may be encouraged to take unpaid days off or vacation without pay. Hospitals have tried different staffing patterns. Some have laid off low skill level personnel. Administrators rationalize that because patients tend to remain hospitalized for shorter periods and because they tend to require complex, sophisticated care, registered nurses (**RNs**) are essential. Some hospitals use a per diem structure **to** staff their floors, calling part-time nurses as needed. Other hospitals utilize differential staffing patterns with fewer low skilled practitioners than before. Whenever possible, however, expensive personnel are replaced with less expensive.

Members of the health care nursing team who do **not** utilize sophisticated nursing skills, who prefer not to work at hospitals, or whose services are not desired by hospitals, are relocating to nursing homes, home care settings, or community oriented jobs. Sometimes these jobs are associated with hospital outreach programs. This move to community type jobs probably will continue, because the cost of hospital care limits the number of available hospital nursing positions. The DRG system also tends to result in patients being discharged from hospitals earlier in their recuperation than before. Therefore health care providers may find their services are more needed for providing care to patients in non-hospital environments.

Patients and DRGs

Patients may be noticing a difference in the nature and extent of care they receive. Patients may be sensing that patient satisfaction **is** not as important to hospitals as it once was. Yet, patients **may** be focal pointa of high pressure merchandising. Hospital administrators seem to want patients to

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stay until the "trim point" period is established, while HMOS urge subscribers to leave before that time. The trim point for a particular DRG is that span of days during which most patients with that diagnosis will be discharged.

Hospitals are paid the same amount for a patient regardless of which day during the trim point period that patient is discharged. It is to the hospital's benefit **to** discharge patients immediately **after** the trim point period is established. Hospitals lose money if patients remain hospitalized to the end of the trim point period. On the other hand, if patients go home before the trim point period starts HMO's save a great deal of money.

Incentives are offered patients to influence them to stay or leave early. The incentives vary from a champagne dinner in the hospital to home care support to be provided by the HMO. Many patients are confused by the DRG system and uneasy about the type and quality of care they receive under it. They, particularly the older population, have been programmed all their lives to do as their doctors say. They are expected to be involved in decision making. However, sometimes they have to make decisions on their own and many patients are uncomfortable with this new role.

Physicians and DRGs

Doctors may be the one group most affected **by** changes resulting from the DRG system. **Many** of them seem not to be enthusiastic about DRGs at best and others seem absolutely to dislike the whole system. They have to get approval from PRO Review Boards before they can admit some patients to a hospital. Their decisions about, and care of, patients are being carefully monitored. They seem to resent being questioned about their practices. Some surgery may be considered unnecessary. So called 'Bread and Butter Surgery" (breast biopsy, gall bladder and knee surgery) requires a second opinion In

addition, some businesses offer 100% coverage for **their** employees if they use the company's health care services. These company's services can be associated with an HMO **or** their own physicians. only 80% of patients' bills are paid by the company for employees choosing to use their own physicians. Thus, many patients are transferring from family physicians. Some doctors are seeing numbers of their patients selecting these options.

Hospitals also are **offering** some services that previously were provided by doctors such as weight control, diabetic maintenance and hypertension clinics. Hospitals seem to be expanding services as a way to survive under DRGs . Doctors are noticing the resulting decrease in income.

Visiting Nurse Association

Another major change associated with DRGs involves the nature and quality of home care offered under this system. Because sicker patients are leaving the hospitals in greater numbers than ever before, home care services, such as the Visiting Nurse Association (**VNA**), must prepare to provide subacute care. Many nurses became associated with the VNA initially in order to avoid having to care for acutely ill patients. They enjoyed the support-care nursing typically needed by a home bound person. However, many failed to update nursing skills. Suddenly there are demands for home care services for patients requiring both subacute and acute care. **Many** agencies are not staffed to meet this new need. Skills of personnel in VNAs must be updated and, in some instances, certified. Additionally, many agencies must now offer 24-hour care where they previously closed at 5 pm.

These and other changes resulting from implementation of DRG systems have created many problems. Many community health care service agencies operate on a voluntary non-profit basis. Suddenly home care is big industry. Agencies

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now must market **their** services, a process which is time consuming and costly. Many agencies lack adequate personnel, let alone personnel trained in merchandising and public relations. Nevertheless, merchandising an agency's services may become essential if an agency wishes to survive. Complicating this problem and undermining some home care agencies **are** businesses that have emerged to address only one aspect of health care. Services offered by these new businesses in almost every instance are profitable ones. These businesses skim money making services that provided sources of revenue for non-profit agencies **initially**. As a result, non-profit agencies must discover **other** means for making sufficient profit to survive. Otherwise, providing care for patients who are unable to pay may spell doom for many VNA agencies.

DRGs and HMOS

HMOS guarantee their subscribers that the HMO's will pay all the medical care needs of their patients after their patients have paid small token payments. Patient treatment typically is conservative and features less rather than more care. It is **in** an HMO's economic interest to hospitalize patients as little as possible. Also, it is to their benefit to have their patients discharged as rapidly as possible from a hospital. Actually, the less care HMOS provide for their patients the more profit they make.

Just as hospitals are trying different ideas under the DRG system, HMOS also are investigating new approaches. One HMO in New Jersey offered to provide home care for its clientele at 95% of what Medicare/Medicaid **patients** paid the preceding year. Naturally the state accepted. Consider, however, that HMOS at this time have no **licensure** or certification audits similar to VNAs. **While** VNAs must prepare for periodic examinations which are time consuming and costly, **HMOS** at this point in time do not. Consider also, the

unfortunate patients who need care but lack insurance. If VNAs lose patients who have insurance to pay for services, how can they survive? VNAs typically have sliding fee scales for services, charging those who can pay to help offset costs incurred against those who are unable to pay. While VNAs receive charitable monies, those amounts diminish as fewer contributions are made by the public. Personnel in VNAs are concerned not only for patients without insurance but also for the growing elderly population. Health problems of the elderly are chronic and debilitating. Are the elderly to be forgotten in the move to cost effectiveness? It may be several more years before the full effect of DRGs on patients will be clearly identified.

Conclusions and Implementations

Few people question that cost containment was needed in health care. Costs were excessively high and increasing each year. Obviously some change was needed, so a cost containment program was begun. Any cost reduction mechanism may have some undesirable aspects. Some undesirable aspects of DRGs are evident. True, the system still is relatively new, but some concerns seem valid. Perhaps some questions about DRGs should be asked, such as: Will health care be governed with minimum consideration for patients? If small community hospitals become unable to survive under DRGs, will patients in remote areas be able to locate facilities to provide health care? How will hospitals maintain or update equipment? Will patient care be reduced to a profit orientation? Who will pay for indigent or poor patients who are unable to pay for service? The questions are easy to ask, but the answers seem non-existent. In health care the human factor should always be the highest priority. Health care providers have humanistic orientations and interests in how DRGs impact on the people being served.

DRGs need **to** be examined regarding their effectiveness and their impact on patients. Change can be fearful because of the uncertainty in causes. High quality health care is far too important to accept a poor quality solution.

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In addition to the above references the following Individuals **were** interviewed regarding their attitudes and experiences associated with the implementation and utilization of the DRG system. Because of the nature of their disclosures, specific statements are not attributed to any particular person.

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